

# MEDICAL DISPUTE RESOLUTION FINDINGS AND DECISION

## PART I: GENERAL INFORMATION

<b>Type of Requestor:</b> <input checked="" type="checkbox"/> HCP <input type="checkbox"/> IE <input type="checkbox"/> IC	<b>Response Timely Filed?</b> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No
Requestor's Name and Address Star Anesthesia, PA 45 NE Loop 410 Ste 900 San Antonio, TX 78216	MDR Tracking No.: M4-03-7372-01
Respondent's Name and Address American Home Assurance Company Box #19	
	Insurance Carrier's No.: 077075003

## PART II: SUMMARY OF DISPUTE AND FINDINGS (Details on Page 2, if needed)

Dates of Service		CPT Code(s) or Description	Amount in Dispute	Amount Due
From	To			
1/23/03	1/23/03	36489	\$152.00	\$152.00

## PART III: REQUESTOR'S POSITION SUMMARY

The Requestor's position statement states in part, "...We are billing for the placement not the monitoring of the CVP..."

## PART IV: RESPONDENT'S POSITION SUMMARY

The Respondent's position statement states in part, "...Carrier has disputed the reimbursement for this procedure because it is already included in the global anesthesia allowance..."

## PART V: MEDICAL DISPUTE RESOLUTION REVIEW SUMMARY, METHODOLOGY, AND/OR EXPLANATION

The Requestor has billed CPT code 36489 and is a starred procedure. The 1996 MFG, Surgery Ground Rule (II.)(A) states, "...The global fee concept for surgical services cannot be applied. The procedures are identified by a (\*) following the procedure code." On this basis, reimbursement is recommended in the amount of \$152.00.

**PART VI: DETAIL FINDINGS (If needed)**

Date of Service	CPT Code	Amount in Dispute	Amount Due	Date of Service	CPT Code	Amount in Dispute	Amount Due
1/23/2003	36489	\$152.00	\$152.00				
				Total Left Column:			\$152.00
				Total Amount Due:			\$152.00

## PART VII: COMMISSION DECISION AND ORDER

Based upon the review of the disputed healthcare services, the Medical Review Division has determined that the requestor is entitled to additional reimbursement in the amount of **\$152.00**. The Division hereby **ORDERS** the insurance carrier to remit this amount plus all accrued interest due at the time of payment to the Requestor within 20-days of receipt of this Order.

**Ordered by:**

Pat DeVries

1/28/05

Date of Order

## PART VIII: YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the Decision and has a right to request a hearing. A request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings/Appeals Clerk within 20 (twenty) days of your receipt of this decision (28 Texas Administrative Code § 148.3). This Decision was mailed to the health care provider and placed in the Austin Representatives box on \_\_\_\_\_. This Decision is deemed received by you five days after it was mailed and the first working day after the date the Decision was placed in the Austin Representative's box (28 Texas Administrative Code § 102.5(d)). A request for a hearing should be sent to: Chief Clerk of Proceedings/Appeals Clerk, P.O. Box 17787, Austin, Texas, 78744 or faxed to (512) 804-4011. A copy of this Decision should be attached to the request.

The party appealing the Division's Decision shall deliver a copy of their written request for a hearing to the opposing party involved in the dispute.

**Si prefiere hablar con una persona in español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**

## PART IX: INSURANCE CARRIER DELIVERY CERTIFICATION

I hereby verify that I received a copy of this Decision and Order in the Austin Representative's box.

Signature of Insurance Carrier: \_\_\_\_\_ Date: \_\_\_\_\_